PSYCHOTHERAPY STRESS-RELIEF SERVICES

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Authorization to Release Confidential Information

I, _____ [Name of Patient] hereby authorize _____[Name of Provider] to release confidential information obtained during the course of my treatment to [Name or function of the person(s) or entities to whom information is to be released] _____.
This Authorization permits the release of the following information:

❑ Any and All Information Necessary
❑ Diagnosis ❑ Treatment Plan ❑ Progress to Date ❑ Prognosis
❑ Clinical Test Results ❑ Dates of Treatment
Other (specify): _____

I authorize the release of the information described above for the following purpose(s):

The specific uses and limitations on the types of information to be released are as follows: _____

The specific uses and limitations on the use of the information by Recipient are as follows: _____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: _____

Signature: _____ Date: _____

_____
[Patient or Patient's Representative]